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ABSTRACT

This study reports on a rural developmental project based on local coordination and Addiction Research Foundation (A.R.F.) community consultation. The purpose of the project is to develop addiction services and general community awareness in a small, northern, rural setting in Hastings County, Canada. The effect of the effort has been the development of an alcohol clinic and an alcoholism education program based completely in the community. The methods used are community consultation on a monthly visitation basis by the A.R.F. consultant. The Clinic and educational efforts have been the result of a coordinated effort between three local agencies and the A.R.F. consultant. The project has been in effect 12 months and is beginning to have some influence on the village and surrounding area. Most importantly, the consultation model is a training model which is ongoing and leaves the community with local professionals skilled in dealing with persons who are addicted to alcohol. The project will continue for a 12-month period and will emphasize professional training for those involved in staffing the Clinic. (Author)

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NORTH HASTINGS ALCOHOL CLINIC

A Rural Developmental Project Based On Local Coordination and A.R.F. Consultation

by

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U S DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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Substudy No. 841

1977

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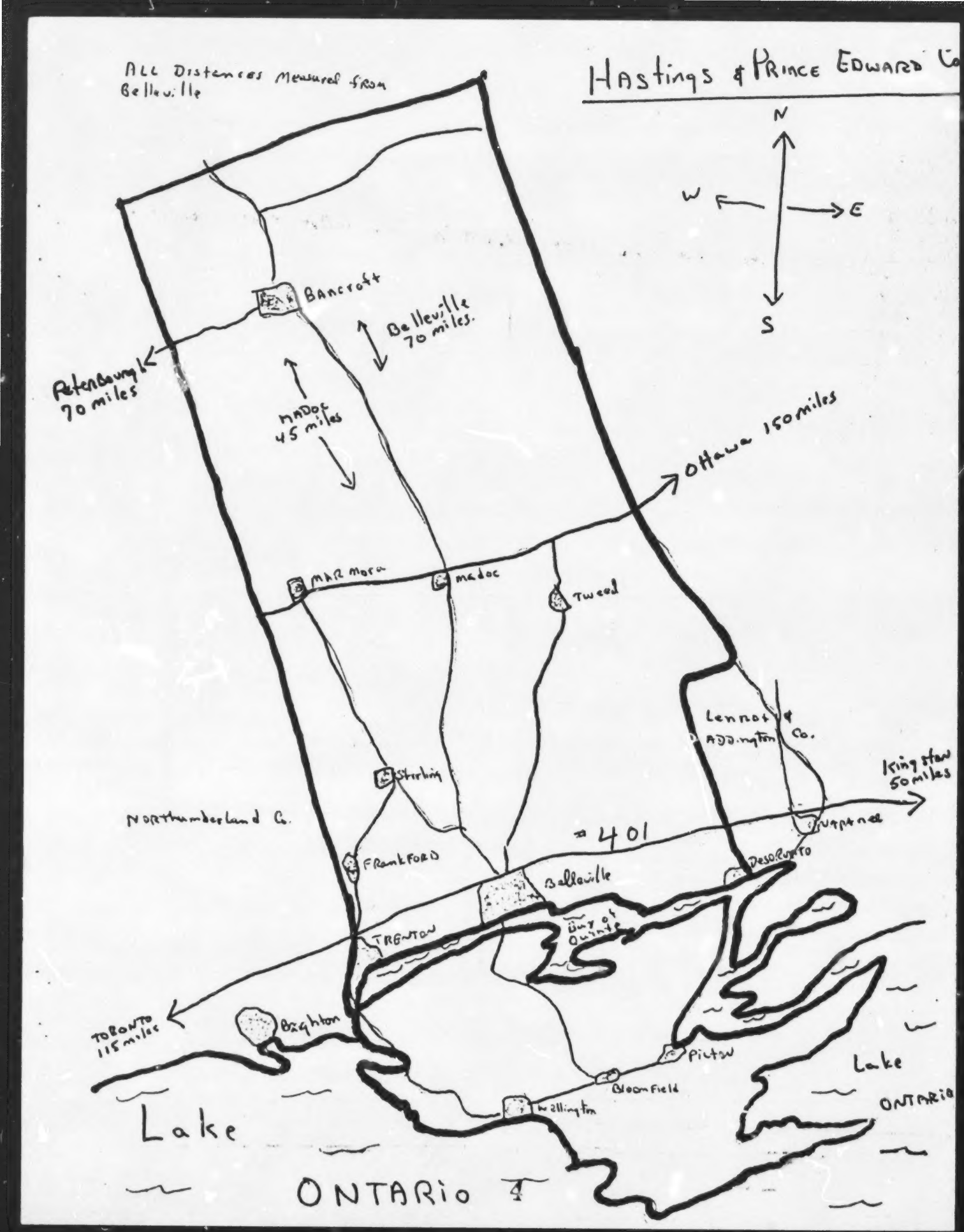
INTRODUCTION

Being a resident of a small, isolated, rural community, you will probably come to accept the lack of specialized human services in your area. Although you may have plenty of solitude, fresh air, end enjoy a non-hectic lifestyle in your small community, you also learn to do without theatres, medical specialists, mental health counsellors, and fancy restaurants. Unfortunately, while doing without social amenities and services is a necessity to rural living, the fresh air and relative calm does not exclude you from certain personal or social problems.

The people living in the relative peacefulness of rural areas experience many of the same personal, medical, and social problems as city folks. One problem common to all communities, rural and urban, large or small, is alcoholism and drug dependency. This paper describes how one small rural community, through professional consultation and agency cooperation, has begun to organize an alcohol clinic to teach the residents more about alcoholism and help those already suffering from the problem. The Bancroft Alcohol Clinic is the first formalized community alcohol service in the two county area of Hastings and Prince Edward, aside from the many A.A., Al-Anon, and Alateen groups already existing. The Clinic provides both a preventive, primary intervention service as well as a secondary or 'counselling' service.

BANCROFT HISTORY

Bancroft is noted for its summer rock hunters' festival, beautiful forest, and lake surroundings. It is a geographical area (between Toronto and Ottawa) in the Canadian Shield with an abundance of lakes, accessible only by float plane, hiking, or small cottage road. As a small community, Bancroft is located in a valley between high hills and has a population


ALL Distances Measured from Belleville
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Belleville 70 miles.
Peterborough 70 miles
Madoc 45 miles
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of around 2,200. The major industry in Bancroft, mining, closed down many years ago. With the closing of the mines, massive unemployment was created, and tourism probably became the major industry. Within the last two years, however, the mining companies have partially reopened their operations and many local people hoped the village atmosphere and economy would be stimulated. The village has been a quiet place to live with many of the old residents remembering when the main street was unpaved.

The social and health services in Bancroft include three physicians, a small public health nursing staff, a couple of welfare field workers, several V.O.N. nurses, one C.A.S. social worker, and a small 22-bed Red Cross Hospital. Aside from these resident professionals, Bancroft has many visiting professional people who come in on a monthly consultative basis, primarily from Belleville and Trenton. These people include vocational rehab. counsellors, A.R.F., school social workers, X-ray clinics, and a variety of others.

Perhaps most interesting about Bancroft, from a service delivery point of view, is its position in the county and the area which is serviced. The village is in north Hastings County and is the only community with social or health offices within approximately a fifty mile radius. The nearest specialized services, hospitals, etc., are in Belleville or Peterborough, both of which are about a seventy mile drive. The Bancroft professional services are responsible to not only the villagers, but also all of those living 'in the hills.' (See map.) There are approximately 8500 people living in North Hastings. In summary, Bancroft is something of an oasis in the middle of the forest.

SOMETHING ABOUT THE 'COUNTY PEOPLE' OF NORTH HASTINGS

The country people living in and around Bancroft are not unusual to other rural areas. There are many socio-economic classes of people represented and there are many 'normal people' as well as those experiencing psycho-social problems. People drawing various froms of Welfare

are often mentioned as 'problems.' On the other hand, there also exists an upper crust of indigenous people who may have problems but keep them well concealed. It is well understood that hiding alcoholism and other forms of mental health problems is highly likely in a small town where everyone knows everyone. These people may own a local commercial business or lumber company and live either in the village or surrounding hills. They usually value preserving their social status highly.

Along with the local residents who maintain social order through a fairly clear class hierarchy, exists a sizeable number of 'cottagers' who maintain a cottage as a second home and visit on a regular basis. Scattered throughout North Hastings are also young-minded people who have forsaken an urban existence to take up an alternative lifestyle in the country. These people are artists, craftsmen, or people with some other craft or professional interest trying to create a different lifestyle.

In some ways, North Hastings people almost deny description. At least one person is reported to be a consultant who flies his own plane and is commuting weekly to Mexico City on a special project. While a two-class system may have once existed, there now exists the remains of a Bancroft social hierarchy combined with many new people who are finding their own 'place.' Tourists, newcomers, and visitors make up the remaining population. It is difficult to provide services to many of the people who reside in Bancroft and the surrounding hills. Not only are the welfare group difficult to reach, but also the upper class are most likely to not seek help in the village. Likewise, the cottagers and tourists will usually only concern themselves with the first aid services offered through the hospital. The rest of the area may either not require human helping services or they do not feel comfortable admitting to personal problems. Yet there exists alcoholism, drug abuse, and other forms of mental health problems.

There seems to be in North Hastings a fairly high visibility of incidences such as incest, inbreeding, child neglect, alcoholism, and other social curiosities. Perhaps, however, most difficult to deal with are the attitudes toward professional and volunteer helpers held by the hill and village people.

A social worker who used to work for a neighbouring Childrens Aid Society described the problem as being 'up against the ethics of the hills' or the 'hillbilly ethic.' While this person's experience was several years previous, the local community nurses still visit one-room heated farms where children receive burns from being too close to the single oil burner. Fearing for one's safety by visiting some back woods farmhouses with second and third generation, often illiterate, welfare recipients is not uncommon for the nurses or local O.P.P. officers. It does not take much imagination to determine the prevalent attitudes held toward preventative health measures, alcoholism, and mental health rehabilitation. Nights are long, women are scarce, 'booze' is available, and what are the choices?

These attitudes toward helping services are fairly widespread and account for some problems in all helping or clinical settings. People often feel stigmatized as a result of seeking help for their personal problems. Not only do welfare persons seem to have a negative attitude toward alcoholism rehabilitation or health maintenance, but other groupings of persons also exhibit avoidance behaviour when confronted with personal problems.

It is likely that many of the people in the hill areas surrounding Bancroft would seem similar to a seasoned health worker coming from the Apalachian or Ozark hill country in the United States. Adding to and solidifying the prevalent health and social attitudes of this area probably is the juxta-positioning of the more affluent cottagers and alternative lifestyles being practiced by the newcomers. The newcomers and the people who come in for holidays are often viewed as foreigners from south Hastings, Toronto, and Kingston. Much as the Ugly American created problems for the Europeans, the local O.P.P. officers feel that the North Hastings 'foreigners' cause most of the snowmobile problems to the area. Perhaps, the cottagers create an analagous problem to the air-conditioned limousines driving along the freeways and viewed by the ghetto dwellers. The ghetto dweller can see the occupant from close, but cannot have any of what he wants so badly. These conditions, sociologists tell us, are prime criteria for production of frustration, sense of hopelessness, and perhaps a need for acting out--an escapism. For some, alcoholism may be explained through escapism,

others may have a psychological need to feel "macho", and for others, it may be ingrained habits seeped in tradition.

It was recently mentioned by a Bancroft physician, that the local hotel's $100,000 renovation did not produce a good dining hall as promised, but rather a good beer hall for the previously, relatively, dry Bancroft. Along with the newly renovated hotel beer hall, came a rash of emergency calls to the local hospital caused by drunken fights in or near the hotel. (Previous to the Bancroft hotel's renovation, the nearest hotel competition was several miles away in another community.) One imagines that the hotel provides outlet for the frustrations some hill and village people may experience, as well as a new 'place to go' in an otherwise socially-quiet village.

IS IT POSSIBLE FOR DRUG REHABILITATION OR PREVENTION TO ENTER THIS ARENA?

In August, 1975, the new Addiction Research Foundation consultant for Hastings County wrote the Bancroft Public Health and C.A.S. workers, suggesting a meeting to discuss ways of assisting in their work with drug dependent people. From those initial meetings, plans were developed which have resulted in three community seminars and organization of a one-day per week alcohol clinic. (See Appendix 1 and 2.) What follows is a description of the Alcohol Clinic, how it developed, and some evaluative comments.

The first meeting in Bancroft was initiated by the Belleville A.R.F. consultant and took place July, 1975. This meeting was an introductory, exploratory one to which Public Health, Victorian Order of Nurses, and the C.A.S. worker attended along with the A.R.F. consultants from Belleville and Peterborough. The message of the first meeting was to "see if a way could be found for A.R.F. to help in providing better overall service delivery to the area, be that an extra body on some schedule, training, or something..." During the first meeting, the Belleville A.R.F. consultant, Don Morgan, offered to present a plan to

the next meeting (August, 1975) that would outline a modus operandi. In essence, what was developed came from a compilation of the minutes of the first meeting and some innovative, directional steps presented by the A.R.F. consultants. The second meeting was called to discuss the proposal for a "pilot project on a community approach to alcoholism in Bancroft." (See Appendix 3.)

This plan outlines a three-part developmental activity: 1) a series of alcohol and drug community seminars, 2) monthly consultative schedule by A.R.F., and 3) organization of a community committee to investigate development of better treatment services. The plan was presented to the second meeting and received enthusiastic replies. The group began to talk about development a treatment program for the area and how a seminar could be best presented. As well, two glaring questions were raised regarding the development of a North Hastings treatment service.

1. Were there sufficient resources available in Bancroft to put together a program?
2. Would there be sufficient referrals made to warrant a treatment program being developed?

Once asked, it was discovered these questions had no immediate answer except by experience and through hindsight. Everyone knew there were plenty of alcoholics in the area, and there was at least a 'usual' amount of drugs and alcohol being consumed in the schools. The question was not in the actual numbers, but in the referrals. Alcohol rehabilitation or reduction of alcoholism, our product, was not exactly hot in demand, especially in light of the prevailing attitudes.

The local "General Practitioners" were felt to hold some answer in as much as most all people did have some contact with a family doctor. The next question was if the doctors would view any efforts of Bancroft Interagency Group as being helpful.

WHAT'S GOING ON?

In effect, a reciprocal consultation process had begun between the local workers and A.R.F. After two months, the A.R.F. consultation provided technical information on drugs, alcohol, adult education, and program development. On the other hand, the local workers added practical information around local resources, friends versus foes, and how to work within the indigenous value and normative system.

In the Bancroft situation, it was apparent that A.R.F.'s limitation was held to a visitation (consultation) schedule. In this way, A.R.F. could inject information, new ideas about how to do things, and some small amount of actual manpower. On the other hand, the resident workers contributed their local knowledge, practical ongoing contacts, caseload, and also some manpower time. It was agreed that a loose Bancroft Inter-agency Group would be formed to sponsor the coming events. Due to the importance of the high school and the local social structure, a young doctor, a guidance counsellor, and a woman involved in the village social structure (wife of a local undertaker) were asked to join the group.

COMMUNITY SEMINAR SERIES

The first order of business was to be a seminar on alcohol and drug dependence. People seemed to hear in town that this would be useful and informative. A.R.F. suggested that there could be a series of seminars providing skill development and general 'attitude' information alternatively to different target groups. As well, the first seminar was to give a public relations function for the rehabilitation service being planned.

The seminar series outline provided for four programs. Over a thirteen month period, November, 1975 to December, 1976, three general information seminars have been held, two in the evening, and one full day program. The two evening programs attracted about thirty people each, and the day program had about fourty or fifty people. Each program relied heavily on A.A. resources, a local physician, A.R.F., and other members of the

Bancroft Interagency Group. The first two programs had small group interaction, which seemed to be more effective than the third program, which featured a film and panel discussion. In general, these seminars, by themselves, probably have little effect on changing drug beliefs and practices. However, taken in combination with other recent media campaigns, they likely add an important touch of 'realism' to the small village. An interesting result of the seminar is described in the following:

> The educational programs' reliance on local A.A. resources gave a higher community profile to the A.A. group, which had not and does not meet in the village (presumably to preserve anonymity). Following the seminars, the A.A. group elected a public relations person who distributed A.A. material to all doctors' offices. One lady made her daughter pick up some of the material so she could read the A.A. literature. The lady is now being counselled by one of the Clinic staff.

BANCROFT ALCOHOL CLINIC

The seminar series was designed for prevention and public relations. The North Hastings Alcohol Clinic is designed for rehabilitation of those already suffering from alcoholism.

Considerable negotiations of an informal sort occurred during September, 1975 and January, 1975 around the type of rehabilitation input A.R.F. and the local resident workers would provide. The basic program points were outlined as early as August, 1975. (See Appendix 3.) However, who would actually provide the service and do the counselling was at issue. On the one hand, the local professionals were concerned about their own time demands and their competence levels, while A.R.F. on the other hand, was concerned about the time demand and the community development mandate.

Ultimately, what emerged was a one day per week Alcohol Clinic, The staff or prime workers would be the C.A.S. worker, two public health nurses, and the V.O.N. nurse (who worked part time for V.O.N.). The staff would take turns seeing clients based on who had immediate time and who had a free caseload. A.R.F. would continue in a consulting coordinator role for a twelve month trial period.

The service provided would be assessment and referral, but also maintenance counselling would be provided for an undetermined time. It was anticipated that the clients and referrals would not flood the clinic, and those that did come would not continue 'in therapy' excessively long. The clinic was held in the back rooms of the North Hastings Manor, which is also where the Public Health, C.A.S., and Welfare workers have their offices. Along with the Alcohol Clinic, the X-ray Clinic, Well Baby Clinics, and other programs are also held in these offices. In this way, a person could enter the building as either a senior citizen, new parent, C.A.S. kid, welfare recipient, or restaurant owner looking for a Health License. No one would know the real reason except the worker and the client.

TREATMENT GOALS

It was felt that if family members or the alcoholic could be brought into contact with Al-Anon or A.A., the clinic's efforts would be regarded as highly significant. If other contacts such as welfare, medical, social, or lifestyle and attitude changes occurred, this would also be regarded as considerably helpful to the clients. Other success criteria would be the apparent usefulness to the client of the medical, social, health, and educational workers. If the clients were to be served usefully, other professional services would most likely need to be involved to deal with the usual multiplicity of problems.

During the twelve months of the official operation, the clinic has had fifteen referrals between the ages of thirteen and fifty-five. This seems to be a reasonable number of referrals, considering the tenuousness

of the clinic, the local attitudes, and the normal start-up problems of any new service. The unique feature to the clinic is in the staff's built-in ability to make home visits and provide immediate access to the services of other agencies. One public health nurse was an Al-Anon member and successfully initiated an Alateen group at the high school in April, 1976. Through her husband's contacts, a group of A.A. members had established contact and support with the Clinic. The V.O.N. nurse as well as the public health nurses, are in close contact with the physicians and the hospital, and all the staff make frequent scheduled visits to the schools. Also, the services of each agency worker are close at hand. Community resources are obviously seen as important in the rehabilitation of the alcoholic client. However, many of the community resources are still reluctant to take a high profile attitude toward addiction as a community problem.

It is interesting to observe how the formal agency support has been granted for the workers to devote their time to the alcoholic clinic. Because the agencies, V.O.N., Public Health, and C.A.S., have a mandate to community work, formal support to the workers' clinic activity has been sanctioned (so long as it doesn't take too much time). Because of the workers' relative isolation in Bancroft, supervision is scanty and requires a great deal of independent work. Approval may also be given out of the distance necessity rather than pure consideration of community development. Regardless of the reason, the staff seem to feel free and encouraged about spending their time in this manner.

EFFECT OF A.R.F. CONSULTATION MODEL ON BANCROFT

From some alcoholics' point of view, it may be that A.R.F. involvement is not appreciated due to the message of control, abstinence, and life-style changes. On the other hand, for those who feel seriously out of control, experience frustration, or have a fear and psychic discomfort from alcoholism, A.R.F. involvement is likely accepted. Among those referred to the clinic, the usual chronic alcoholic influence was apparent.

Among those successfully referred to Al-Anon, Alateen, or A.A. from the Clinic, significant influence seems to have been felt in that family, according to public health follow-up visits.

A.R.F., like any agency or service propounding lifestyle changes, requires a public image. In many communities, A.R.F. seems to have an image which consists of expertise, research, doctors, and a few other 'people.' One often gets a sense of being a curiosity object. An analogy comes to mind of the radial tire salesman opening a new territory at the North Pole. "Nice chap and great product but really quite useless to 99% of us."

A.R.F. has through collaboration and consultation developed a little more useful "corporate image" to the consumers in North Hastings. In terms of the A.R.F. mandate, we have relieved a sense of responsibility to the people of North Hastings County. Most importantly, we are providing service to the area within the cost effective restrictions imposed on us from the economic, legislative situation.

To the local nurses, doctors, and others in the area, the consultation model does not do their job, but attempts to backstop the services they already provide the community. Actually, much has been written elsewhere regarding the effectiveness to local services through a consultation model. 'Pleasure surveys' have not been conducted to illicit a constructive critique of the Bancroft consultative process as felt by the consultees. It does, however, seem helpful and appreciated to have an 'outsider' available to share in the risk involved by trying out new activities, such as community seminars, medical meetings, and development of a "clinic."

Some of the benefits to the area which have become apparent through the project are as follows:

1. The community is left on its own most of the time and not 'bugged' by the professional.

2. On the other hand, pressure for change is maintained through implicit action expectations of the consultation meetings.

3. Consultation does not do all of the job, but forces skill development of the resident workers.

4. The servicen developed are more comfortable to the area. They are not too flashy, but still look important.

SUMMARY IMPRESSIONS OF THE PROJECT AND MODEL DURING FIRST TWELVE MONTHS

The project is actually eighteen months old considering the initial start-up phase. It took about four or five months' discussion, planning, and negotiating before an official start date for the clinic actualized. Unless one is prepared to do the entire thing alone, a consultation or interaction model is the only available method of starting up a service. The clinic service is functioning and seemingly effective in terms of having some influence over referrals to A.A., Al-Anon, and Alateen. Determining changes in the alcoholic or family attitudes are difficult to discover; however, through public health home visits or other follow-up methods, the clinic is having some impact on its clients. The medical community continues to make referrals as do other sources.

Awareness of alcoholism has grown in the village. Previous to the seminar series, alcoholism was a taboo subject. It is now apparently being discussed. A.A. was invited to speak over the local radio station, and an O.P.P. officer indicated a change in his own and his colleagues' attitudes toward acloholic offenders. The Clinic's existence provides for a 'presence' or symbol of alcoholism in the community. Yet from another analysis, it only provides a new facade behind which the same old workers are offering almost the same service they previously provided.

The first year appeared to be (in hindsight) a demonstrative phase. By its continued existence and community seminar series, and group has overcome a "Can they really do it?" hurdle. Still, there are problems in overcoming the prevailing attitude toward mental health, prevention, and alcoholism. These attitudes exist not among the village lay people,

but also the professional groups. Educating people how to use a new service when they have had to do without for so long is a large task in itself.

WHAT COMES NEXT FOR THE NORTH HASTINGS ALCOHOL CLINIC AND THE BANCROFT INTERAGENCY GROUP?

In the first place, the Alcohol Clinic probably needs to develop more of a clientele. If the product is counselling and rehabilitation, than a sales job needs to be done in order to bring out more potential customers. This perhaps could be done by making the staff more available to the doctors' offices and the adult and family court. In a sense, the client-getting phase would be a form of on-the-spot in-service training for those who are in close contact with alcoholic people; for example, the O.P.P., judges, and medical community. The training could be assessment and referral training.

Quite likely, the only method for accomplishing this educative and client-getting activity would be a more aggressive attitude taken by the clinic staff. By aggressive, it is meant more of a community outreach attitude. On the other hand, it may be that the clinic staff are not able to work in this manner due to other responsibilities connected with their primary job. If this is the case, a part-time, paid coordinator would likely be required. A second new direction might be to train the clinic staff to act as consultants for other professional groups in the area. This might take the form of a training program in the consultation model. In this way, the consultees of the last eighteen month project would become the consultants to other Bancroft professionals in the area.

Both possible new directions have to be explored with the committee, and some decision needs to be made in the coming months.

POST SCRIPT

An evaluative meeting was held in January, 1977 whereupon a decision was made to continue the project for another twelve months. The group opted for the continued consultation option. The next year will see efforts directed toward polishing the services offered by the Clinic by in-service training and more outreach.

DM:ps
January, 1977

APPENDIX 1

BANCROFT SEMINAR SERIES

"Alcohol & Drug Dependency"

(Working Outline)

August 18, 1975

Sponsored by:

Bancroft Interagency Group

Seminar Consultants:

Addiction Research Foundation

The purpose of this seminar series will be to provide the interested professional and lay population of Bancroft with more information and skills for dealing with alcohol and other drug dependencies.

There will be four separate seminars providing theoretical and practice background to better cope with addiction problems. These seminar series will be directed toward those generally interested in this topic as well as those individual professionals or citizens wishing to develop their specific skills and talents at working with dependent people.

Seminar One: 'Overview'

This will be a general overview to the problems encountered in alcoholism and other drug dependency. This seminar will be a day long and should cover the following areas:

1. Definition of alcoholism and drug addiction
2. Range of problem in Canada, Ontario, Bancroft
3. Specific nature of the problem: Family, individual deterioration, employed problem drinker, school age drug use
4. Treatment of Alcoholics and drug dependent people.
   a) Formalized programs (Peterborough, Kingston, Oshawa, Toronto, Ottawa)
   b) Resources and procedures available to Bancroft
5. Etc.

Seminar Two: 'Skill Development'

This seminar will be a half a day long (four hours) and may be viewed as 'staff development.' The emphasis will be on actual skill development around some specific job such as "interviewing the alcoholic individual" or "interviewing the youthful drug abuser." In this sense, this day will be a 'practium.'

Seminar Three: 'Skill Development'

A repeat of the above only with a different topic--such as, "interviewing the alcoholic and his/her family" or "follow-up interviewing."

Seminar Four: 'Open'

This will be scheduled as a day long program but the topic and 'agenda' will be left open. The program can be planned as new issues and ideas arise or the day can be dropped depending on the participants' attitudes.

It was suggested that the seminars be held every one to two weeks. The first seminar would be held in mid-October.

A local committee would sponsor the series with ARF acting in a 'resource consulting' role.

The first seminar would serve to advertise the 'B' part to the Pilot Project--that is direct service assistance by ARF.

APPENDIX 2

BANCROFT ALCOHOL & DRUG ADDICTION SERVICES

(Working Outline)

August 18, 1975

Sponsored by:

Bancroft Interagency Group

Consulting Services:

Addiction Research Foundation

ALCOHOL & DRUG ADDICTION SERVICES

The attached general points outlining the program were agreed to in principle. There are several points which need to be clarified such as the referral procedure.

It was felt that educating the professional people would be an important job in order to receive appropriate referrals. It was also felt important to make the service as accessible to the unique needs and habits of Bancroft's residents. Another problem area was felt to be in getting those in need of help to agree to get help with their problem.

While several details still need clarifying it was felt that informally we could begin discussing cases during the time we are planning the seminar series.

While the ultimate aim might be to create a local Addiction Services Unit, the minimum expectation will be to assist the local service providers to learn how to better help those dependent persons overcome their psycho-social-dependent problems.

The attached points outline the direct service delivery.

MONTHLY VISITS TO BANCROFT

1. The referral procedure is yet to be developed although it will probably be either an open system (available to all) or a closed system available only through a physician. (B.I.G. and Doctors)

2. Referral source (agent) must participate in interview at least in the follow-up recommendation time (over phone if necessary) from doctors alone.

3. Interviews will be in nature of: assessment, problem identification, and follow-up therapy recommendations.

4. Client evaluation interviews every four months (when possible).

5. Specific follow-up interviews and consultative support in case conferences with area workers each month or as required.

6. Meetings at Hastings Manor or some other convenient facility.

7. Times (interviews) coordinated through Shirley (secretary).

8. Phone contact with ARF available in between visits.

9. Client reports made to referring agent and or prime worker and ARF (Belleville).

10. Project documentation (evaluation) will be responsibility of ARF.

11. Inpatient back-up to be arranged with the most appropriate and accessible service in/either the local hospital, Peterborough, Kingston, Oshawa, Belleville, etc.

APPENDIX 3

SUGGESTIONS FOR A PILOT PROJECT ON A COMMUNITY APPROACH TO ALCOHOLISM IN BANCROFT

The Addiction Research Foundation of Ontario, in 1971, placed a consultant in Belleville to assist the residents of Hastings and Prince Edward Counties to look after and rehabilitate those who were alcohol or chemically dependent. This office was also interested in helping prevent the increase of dependency problems. The Belleville office was established by Mr. Bill Becks, who is currently the Director of Peterborough's ARF operation. At the present time, Don Morgan is the ARF consultant for Hastings and Prince Edward Counties.

In Hastings and Prince Edward Counties there are few formalized treatment or helping services for the person suffering from alcoholism or chemical dependence. However, scattered in and around this area are many separate resources, which if united and reoriented, could begin to more effectively work toward alleviating the current problem situation.

The individual with alcohol or drug problems is difficult to help and the personal rewards of helping this person are scarce. To achieve even a resemblance of a alcohol and drug treatment network will require considerable work and effort by many people.

There are no secret tricks to helping the alcoholic person, although some skills are more useful than others and all skills are often required. Most all of the components to a formalized alcohol treatment program exist already in some form in almost all communities! Leisure time workshops, life skills training, various therapies, nutrition and health counselling, and adult education are all important to most current treatment programs and exist in some form within, for example, Bancroft.

The question of course is how to identify those willing resources or convince others to organize into a community approach to working for the rehabilitation of alcoholics and prevention of alcoholism as an increasing health and social problem.

With an eye toward achieving this ultimate end (a community approach to dealing with alcoholism), let me outline the areas of apparent agreement resulting from our meeting at the Hastings Manor on July 8.

1. A series of workshops or seminars on Alcoholism and Its Treatment, focusing on theoretical notions as well as the more practical skills, constraints, and strengths found within the Bancroft community. (During the fall of 1975)

2. Monthly visits by Don Morgan to provide direct service in the areas of assessment, consultative back-up, and treatment recommendations.

3. Assist in a possible community committee to investigate development of better services for Bancroft's problem drinking population.

I would like to suggest that we get together and work these agreement areas up into a Pilot Project, which could test the feasibility of developing, in Bancroft, a 'Community Approach to Alcoholism.'

This idea sounds rather ambitious so we would probably want to begin small and set our sights on achieveable objectives.

What do you think of a Pilot Project which includes, a) an educational and training emphasis, b) direct service consultation, and later on c) a group to investigate specific alcoholic problems and recommend and initiate action steps.

If you like this beginning notion please understand that the last part of the pilot project (c) formation of the community group) would be

expected to, increasingly, take over parts a) and b) (education and direct service). ARF would still, however, remain active in a consultative and supportive role.

At present, I am thinking of approximately a twelve-month period as a running time for this project.

The suggestions I have given, regarding length of time and Pilot Project Program, need to be discussed by us all and changed according to what will or won't work. There is no reason why we can't, however, begin to plan the seminars right away. Bill Becks, ARF Peterborough, has agreed to help us in planning for this part.

I would like to suggest a meeting to disucss my proposals and in some way ratify what we do next.

July 18, 1975

Don Morgan